Meeting: Strategic Commissioning Board			
Meeting Date	05 October 2020	**Action**	Consider
Item No	17	**Confidential / Freedom of Information Status**	No
Title	Form and Function of the Local Care Organisation		
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Executive Summary

The purpose of this paper is to consider the organisational form for the Local Care Organisation (LCO) in Bury.

The LCO has been operating as an alliance partnership in Bury for some time and have made a valuable contribution in bringing a focus on the integration of community based health and care services in the borough, and taking lead responsibility for a number of the recovery and transformation programmes of work.

Leadership from both CO and LCO in Bury consider it important to clarify for the medium term, the form of the LCO, in order to provide certainty and to allow the LCO to focus on delivery. Likewise, partners within the LCO have recognised the need to address the LCO's organisational form at various points since its inception but only recently has there been a consensus that the sustainability and effectiveness of the LCO require a conclusion to be drawn on organisational form.

Recommendations

It is recommended that the Strategic Commissioning Board:

- is invited to receive the paper and comment on the rationale and description of the lead provider role for the LCO
- is invited to note the next steps being taken and to provide comment.

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

Implications						
Are there any quality, safeguarding or	Yes	☐	No	☐	N/A	☐

Implications						
patient experience implications?						
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☐
Are there any financial implications?	Yes	☐	No	☐	N/A	☐
Are there any legal implications?	Yes	☐	No	☐	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☒	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☐

Implications	
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*

Governance and Reporting		
Meeting	**Date**	**Outcome**
Add details of previous meetings/Committees this report has been discussed.		

Paper for Strategic Commissioning Board – October 2020

Form and Function of the Local Care Organisation.

1. Introduction

The purpose of this paper is to consider the organisational form for the Local Care Organisation (LCO) in Bury.

The LCO has been operating as an alliance partnership in Bury for some time and have made a valuable contribution in bringing a focus on the integration of community based health and care services in the borough, and taking lead responsibility for a number of the recovery and transformation programmes of work.

Leadership from both CO and LCO in Bury consider it important to clarify for the medium term, the form of the LCO, in order to provide certainty and to allow the LCO to focus on delivery. Likewise, partners within the LCO have recognised the need to address the LCO's organisational form at various points since its inception but only recently has there been a consensus that the sustainability and effectiveness of the LCO require a conclusion to be drawn on organisational form.

There are a number of key drivers which make this an important issue to consider now and which have contributed to both the OCO and LCO agreeing that form needs to be decided. The wider system drivers include:

1. Recognition that much of the management capacity of the LCO is based on short-term transformational funding, available until April 2021, and resolution is required soon to avoid loss of staff and associated knowledge and expertise. The LCO has fulfilled a role in the system that individual organisations have been unable to do, due to capacity challenges and the independent and co-ordinating nature of the LCO team, in the main. This will create a void if the LCO is not there, thereby de-stabilising the ability of the system to deliver the level of transformation required to support recovery.
2. The OCO have been asked for a contribution to the funding of a Bury-based Northern Care Alliance NHS Group (NCA) leadership, reflecting the disaggregation of the Bury and Rochdale Care Organisation into two distinct teams (instigated by Rochdale but helpful to Bury to have the focused NCA leadership in this 'place' exclusively). This is an additional ask for management capacity in the economy, which needs to align with capacity and capability for the LCO.
3. The OCO need to resolve the question of re-procurement of the community health services contract due for commencement April 2021

As noted, the Board of Bury Local Care Organisation (LCO) is also keen to examine the best form of organisational and contractual structure to take effect from April 2021 in order to specific delivery issues including:

a) Strengthen the potential for further integration of health and social care services, capitalising on learning from the Covid-19 emergency period and the redesign of urgent care services

b) Provide the means to hold contracts from commissioners, and the means to hold sub-contracts with providers, e.g., those not currently members of the LCO

c) Provide a platform for 'blended roles' between Bury's One Commissioning Organisation and the LCO, e.g., to support pathway redesign
d) Maximise Bury's potential to adapt to a potential establishment of integrated care systems on a statutory footing

2. OCO specification for the LCO

The objective of the Bury LCO is to oversee and co-ordinate the delivery of good quality integrated community-based health and care services. These services are predicated on strengthened primary care, are based on the 5 neighbourhood model in the borough, are focused on prevention and early intervention, and are characterised by having a different and asset-based relationship with residents and communities. The LCO is a partnership between health services, social care and wider support and wellbeing services. It seeks at all times to be inclusive of its members' principles and to create an ethos in which there is 'parity of esteem' not only between physical and mental health but also between health and social care, between all the professions in the sector, and between organisations of the state and independent organisations working with the state, such as the voluntary and social enterprise sectors.

The LCO is expected to provide a focal point and integrated leadership arrangements for delivery of health and care, spanning a number of organisations and delivery mechanisms including:

- Primary Care and Primary Care Networks
- Social Work and elements of social care delivery (Bury MBC and commissioned providers)
- Mental Health (Pennine Care NHS Foundation Trust)
- Community health services (NCA),
- Voluntary, Community and Faith Alliance

All of these organisations and sectors are directly connected to the transformation of acute hospital services, which can only be truly radical with the right integrated community support in place. We would also see strong connections to other key providers in neighbourhoods such as care homes, care at home services and neighbourhood voluntary community and faith organisations, in line with the need to build on individual and community assets, reduce the risk of people's needs escalating, and of enabling everyone to maintain their independence for longer.

Integrated neighbourhood team leadership should be strengthened – co-ordinating and orchestrating the combined contribution of providers in the neighbourhood. We do not consider it necessary for all members of a high functioning multi-agency team to be employed by one organisation. We have demonstrated though our collective Covid-19 response that a common goal can bind teams together under distributed leadership regardless of employer or the formality of the partnership governance. The objective is to secure and build multi-agency teams, where front line staff are empowered and supported to be working together as if they were one organisation, being guided by expert leadership that is organising the most effective ways of working.

While employment arrangements may not need to change, we do need to establish a consensus on the extent to which authority to 'manage' staff can be ceded by different organisations into single management arrangement for multi-agency teams – particularly for NCA community nursing staff, council adult care staff, and Pennine Care neighbourhood team members. It is important to establish the principle that neighbourhood management team can direct and support the work of the multi-agency team in the neighbourhood. Neighbourhood working needs to be more than just co-located teams.

We also do not expect the notion of integrated team working to undermine professional accountability arrangements – for example in social care, accountability to the Director of Adult Services - or professional nursing networks. In fact, we believe that strong professional accountability networks are a pre-requisite of multi-agency neighbourhood based team working.

We expect an LCO to be the representative voice of all partners to the arrangement – and further expect that partners mandate the LCO board to make appropriate decisions, within a scheme of delegated authority, without the requirement to seek further endorsement from the board of each partner.

We will work to ensure that the OCO and the LCO have a positive working relationship – operating seamlessly as one health and care system on behalf of the residents of the borough. This reflects the principles and behaviours document governing the OCO/LCO relationship agreed in June 2019. In this we expect staff nominally associated with the OCO or the LCO to be supported to make the best contribution they can in a co-ordinated way to the operation of multi-agency neighbourhood based team working.

We are keen to create the space for the LCO to strengthen its delivery of integrated community services – through neighbourhoods and programmes like active case management implementation – at a scale that begins to impact on both on the key metrics for the system – urgent care demand, and formal packages of social care – and the wellbeing of Bury people.

An important characteristic of the LCO should be the ability to move money around the system to secure the investment required in community-based health and care. For example we currently have a relative surplus of intermediate care beds, but a reablement team funded almost entirely on short term transformation funding. Our ability to close beds and invest in the team is limited due to the block nature of the contract.

3. Options

The LCO and OCO have undertaken high level options appraisals independently, with the following perspectives being obtained:

No.	Option	Brief description	LCO perspective	OCO perspective
1	*Status quo*	The current arrangement is an alliance between seven organisations, governed by an Agreement which is not legally binding, supported by dedicated management capacity	Not sustainable in the long term as it does not provide sufficient capability to move integration to more advanced levels, e.g. cannot hold contracts and has no independent decision-making power	Not satisfactory because it does not create certainty and does not create the scope for moving money into community based prevention and early intervention

No.	Option	Brief description	LCO perspective	OCO perspective
2	*Section 75 arrangement*	A step on from the alliance would partners retaining all existing sovereignty, but to pool a proportion of the LCO in scope budget under a section 75 agreement – in a mirror to the pooled budget arrangement within the joint commissioning board.	Not sustainable in the long term as does not provide sufficient capability to move integration to more advanced levels, e.g. cannot hold contracts and has no independent decision-making power	This has potential depending on the scope of the pooled budget proposed, but may be regarded as avoiding a key question of drive and leadership for the ambition of the LCO. This should not be discounted as it is another way of maintaining independence and providing relentless focus on community based care capacity and integration
2	Contractual joint venture	This would not represent a major change from the status quo, as a contractual joint venture would have the same limitations as the current arrangements	Not sustainable in the long term as does not provide sufficient capability to move integration to more advanced levels, e.g. cannot hold contracts and has no independent decision-making power	This creates an additional player, management cost, and is contractually challenging for reasons of VAT.
3	Special purpose vehicle (SPV)	This could take a variety of forms, a social enterprise being the most likely and easiest to establish. The SPV would have a legal identity and be a body corporate and as such it could hold contracts and let contracts.	This model provides for maximal control of the LCO by its 'owners', the provider partnership but it would create a new organisation in the borough. Transferring existing contracts for services to the SPV would most likely require a procurement exercise, and could be costly and time consuming	The system cannot afford the additional overhead costs involved to build the necessary corporate and clinical governance arrangements.
4	Lead provider	This option could take a variety of forms including: a) a single organisation which holds a major contract from commissioners and which sub-contracts to other providers, integrating care and co-ordinating care pathways b) a single organisation which employs all or most community health and social care staff and which holds a major contract with commissioners which it largely or exclusively fulfils directly (i.e., not through an	Each of these options has its own profile of merits and demerits and there are variations of each not described here. A lead provider model with a strong focus and infrastructure to manage relationships and partnerships, would enable the LCO development to move to the next level, and to continue the focus on true integration	There is little support for a model which would mean large-scale organisational change and disquiet for front line staff, particularly in social care, at a time of considerable uncertainty. It is also likely that direct employment change, would also involve some challenge around VAT There is also a sense that building integrated neighbourhood teams with integrated leadership arrangements is not dependent on managerial authority derived from employment status.

No.	Option	Brief description	LCO perspective	OCO perspective
		independent network or supply chain) c) a single organisation which holds contracts and provides infrastructure support (and in addition some direct services) but which supports and sustains a concrete partnership of organisations to which it delegates as much decision-making power as possible		A lead provider arrangement would provide confidence and certainty in leadership - a 'cleaner' solution, and would create scope for a single management team nested within the corporate and clinical governance of a provider. However the partnership arrangements supporting decision making would need to be robust, so that community care would not be a secondary consideration, as out of hospital care is the prime focus for the LCO

Based on high level separate options appraisals undertaken separately by the LCO and the OCO, it was agreed by the LCO Board, that the description of the lead provider form should be progressed. This step has been taken principally because there is limited or no support within Bury for the creation of a new organisation (option 3) and the sustainability of the current arrangements is now generally agreed to be at risk as a result of a variety of factors, thereby eliminating options 1 and 2. There is strong consensus that any lead provider model established should not undermine the Partnership and relationships that have been built over recent years.

4. Assumptions

The LCO Board (which includes OCO membership) has agreed the following assumptions with regard to the next stage of its development

- The LCO will be a means of co-ordinating integrated out of hospital care and support, care and support that is itself fully aligned to the borough's hospital provision for physical and mental health, the provision of which is the direct responsibility of LCO members. The LCO will have a role in directly managing some aspects of provision (where appropriate), and integrating providers across the Borough to deliver more effective and efficient care. The LCO will include acute provision for urgent care, however where services are managed on a broader footprint than the Borough, the LCO will ensure robust connectivity into associated pathways e.g. surgery and diagnostics

- The LCO must preserve through the next stage of its development, the trust and relationships which have been built over recent years

- The LCO must focus on prevention, early intervention, and having a different relationship with residents, communities and service users. Social care, and the voluntary sector, must be seen as equal contributors within the LCO arrangements.

- The LCO arrangements should enable partnership working at an advanced level to support and enhance community healthcare services, currently hosted by Northern Care Alliance NHS Group

- The LCO must be able to co-ordinate the work of providers and commissioning staff (e.g., working in 'blended' roles) without triggering any organisational change process which would, e.g., result in a transfer of employment unless this is mutually agreed between affected parties

- The LCO must be future-proofed as far as possible so as to be able to operate in a variety of scenarios including the establishment of a statutory integrated care system for Greater Manchester – the direct provision of services

- The LCO should always minimise the risk of creating additional layers of management or duplicating arrangements in other organisations

The following principles of the lead provider model were approved by the Board

- The LCO needs to maintain a Board and infrastructure to support the integration and delivery agenda that operates at arm's length from the lead provider to support partnership working. This infrastructure may reduce over time, as confidence grows in new arrangements. It is anticipated that it will be required as a minimum for 1-2 years. The LCO must preserve the trust and relationships which have been built over time.

- Keeping the LCO structure as lean as possible to deliver the ambition of

    - Being an integrator of all health and social care services to transform the delivery of care across the Borough
    - Directly managing a suite of out of hospital services which are delegated to the management team of the LCO for transformation and day to day operational management

- Infrastructure and necessary HR processes must supports be designed to support business continuity, and in the context of the latest national, Greater Manchester and North East sector direction. The creation of the LCO form will minimise employment transfers as much as possible, and will not impact on VAT arrangements

- There will be a journey of contracts aligned and managed by the LCO rather than a wholesale change immediately

- All providers will be asked if they wish to express an interest based on the outline description of the lead provider model

5. Outline of Bury's lead provider model

5.1 Summary of LCO role

Bury Local Care Organisation will be a partnership between provider organisations in the context of a lead provider. The lead provider will be (most likely) a major provider of out of hospital services itself, though decisions about the transformation and delivery of these services will be delegated to the LCO Board.

The LCO will provide management including single line management for some community services and will act as an integrator for the wider community health and social care sector by co-ordinating the supply chain and associated pathways of care.

The LCO will seek at all times to maximise the value of a range of different and distinct providers in Bury, believing that Bury people are best served by co-ordinated care from a range of distinct, unique organisations, rather than from a single body or from a few organisations only.

5.2 Role of the lead provider

The role of the lead provider will be to:

- Employ the staff who manage the LCO (executive team and core team)
- Hold contracts from commissioners for services provided by the LCO
- Sub-contract to providers on behalf of the LCO, co-ordination and integrating the LCO supply chain, these contracts having been transferred to the lead provider by the commissioners
- Provide infrastructure support including technical and professional support
- Permit secondments, or forms of 'blended working' from LCO partner organisations and from commissioners
- Hold any programme budget or pooled fund on behalf of the LCO on the basis of an agreed risk-and-reward share with commissioners and providers. This will be of critical importance with regard to the urgent care programme budget
- Delegate the management of its own community services to the LCO Board, executive and management team on a day to day basis.

5.3 Role of the LCO Board

The LCO will be governed by a Board which shall consist of full members of the LCO. The Board shall be independently chaired, and will have delegated powers from the full members to make decisions about:

- Transformation and redesign of services
- Use of resources in the context of any programme budget or pooled fund
- Deployment of the LCO's resources i.e., those resources made available to the LCO by commissioners and LCO partners
- The performance and quality of services contracted from the LCO and from sub-contracted services
- Membership of the LCO

- Policies and procedures used by the LCO
- Recommendations being made to the lead provider in respect of contract variations and contract letting

The lead provider shall additionally delegate to the Board of the LCO the powers to:

- Transform and redesign community services provided by the lead provider or contracted for by the lead provider in order to maximise the opportunities from integration
- Manage the lead provider's community health services in the context of integrated health and social care services and pathways, on a day to day basis
- Make recommendations which the lead provider would accept in all but exceptional circumstances for the letting or variation of contracts and sub-contracts

Full members of the LCO shall be provider organisations which will delegate to the Board of the LCO, via the lead provider, the following powers:

- Power to manage contracts for services provided by the member organisation, whose contract or sub-contract is routed through the lead provider
- Power to transform or redesign services provided by the organisation in order to maximise the opportunities from integration
- Power to manage services from the organisation on a day to day basis, through the LCO management team and executive, reporting to the Board

The LCO Board may, in the future, be:

- A regulation 10 committee under Statutory Instrument 2000 617 in the event of the partners agreeing to establish a s75 agreement (NB, there is no current facility to include non-council or non-NHS bodies in a 75 agreement)

- A joint committee in common (NB, there is understood to be currently no facility for a non-NHS body to join a committee in common as a voting member)

- A sub-committee of the Board of Pennine Acute Hospitals NHS Trust (NB, there is understood to be no facility for a non-NHS body to join such a committee as a voting member)

These limitations may be addressed in the event of legislative changes to establish integrated care system as statutory bodies. In any case, the LCO Board needs to be able exercise autonomy within the context of the lead provider: in other words, the governance of the LCO needs to balance the regulatory and contractual obligations of the lead provider with the need for partners to exercise a genuinely meaningful decision-making power over matters which concern the LCO.

5.4 Implications for LCO member organisations

The following implications have been identified for LCO member organisations

- There is some loss of control of services, but this is partially mitigated by the voting rights that each organisation has on the LCO Board (which will remain one organisation, one vote)

- For some organisations and some services, their 'customer' may become the lead provider through the LCO Board, rather than the One Commissioning Organisation

- There will be some potential to increased exposure to financial risk, depending on how the risk-and-reward arrangements are operated but correspondingly there is likely to be an increased potential for financial reward for reinvestment

- There will be a significantly increased potential for seeking new business opportunities in partnership with the lead provider

6. Next steps

The LCO Board meeting on 7th October will be used for a discussion between partners to the LCO to be able to describe the key characteristics of the lead provider model and the LCO form and the conditions for success, based on the views of partners. Partners have been asked to complete a template gauging views on a number of aspects of the role and operation of a lead provider model and also provide an indicative view on their interest in becoming a lead provider.

7. Recommendations

1) The SCB is invited to receive the paper and comment on the rationale and description of the lead provider role for the LCO
2) The SCB is invited to note the next steps being taken and to provide comment.